



WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ SSN: _____ - - Employer's Name: _____
Address: _____ Address: _____
City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____
Home Phone: () - Work Phone: () - Insurance Carrier: _____
Preparer's Name: _____ Law Firm: _____ Preparer's Phone #: () -

Complete each information blank. To request a hearing, check Box 13b., indicate the kinds of benefits claimed by checking the box(es) at Lines 6, 7, 8, and 9, and file this form in duplicate.

A claim for workers' compensation benefits is made based on the following grounds:

- 1a. The claimant sustained an accidental injury to _____ (Part of Body Hurt) ON _____ (Month Day Year) in _____ County, State of _____.
- 1b. Briefly describe how the accident occurred. _____
2. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
3. The relationship of employer and employee existed at the time of injury.
4. At the time of the injury the claimant was performing services arising out of and in the course of employment.
5. Notice of the accidental injury was given to the employer on _____ (Month Day Year) in the following manner: _____
- ☐ 6. Due to injury, the claimant is in need of (check one):
☐ (a) medical examination and treatment for: _____
☐ (b) additional medical examination and treatment for: _____
- ☐ 7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of: _____
- ☐ 8. Due to the injury, the claimant has permanent disability of the following nature and extent (check one):
☐ (1) General Disability: ☐ Total ☐ Partial ☐ (2) Specific Disability: ☐ Total ☐ Partial
Body part(s) affected are: _____
- ☐ 9. Due to the injury, the claimant has a serious bodily disfigurement consisting of _____
- 10a. At the time of the injury, the claimant was paid weekly wages of \$_____, and demands accounting of days worked and wages earned as provided by law.
- 10b. Give names and addresses of all employers for whom the claimant has worked since the date of the accident: _____
- 11a. Further grounds of claim: _____
- 11b. List names and addresses of all physicians or other medical specialists who have seen or treated the claimant as a result of the accident: _____
- 11c. To the best of your knowledge, did you have any prior permanent disability? _____
If yes, describe: _____
12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.
- ☐ 13a. **I am filing a claim. I am not requesting a hearing at this time.**
- ☐ 13b. **I am requesting a hearing. A \$25 fee is required.**

Signature of Claimant/Representative _____ Date _____

Refer to R.67-205 and R.67-206 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Judicial Department.